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ABSTRACT

The authors discuss the origin of special education services, especially psychological services, in the public schools of New Jersey and their implementation in Region III of Bergen County. The roles and methods of the special education coordinator and consultant psychiatrist are explained. The psychiatrist-author reviews 5 years' (1969-73 inclusive) experiences examining and diagnosing 162 referred children (4- to 14-years-old). Data are analyzed to substantiate findings such as the following: that 87 of 162 children manifested organic handicaps, that psychiatric illness was diagnosed in all but two cases, that schizophrenia was found in seven children, and that medication was considered advisable in 88 of 162 cases. Problems besetting special educators and consulting psychiatrists are said to involve reluctance to establish special classes and the rigidity of current classificatory systems for handicapped children. (GW)

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Special education services for the handicapped child in a suburban area of New Jersey involve a special education coordinator and a consultant psychiatrist. Five years' diagnostic experience demonstrated a high incidence of "organicity," not surprisingly. Most children examined displayed "mixed" rather than "pure" kinds of handicap. Many complications ensue in the effort by professionals to insure beneficial classroom placement of the exceptional child. Special education remains a controversial field.

Five Years of Special Education and Psychiatry in Suburbia

A Review, Survey, and Critique

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One of us has served for more than five years as consulting psychiatrist and the other has been coordinator for a regionalized special education program in Bergen County, New Jersey. Classes have been set up for the emotionally disturbed, trainable and educable retarded, and neurologically impaired to the extent that space, money, and tolerance from the superintendent, in whose district the class is housed, is available. It is difficult intelligently to arrange homogeneous classes for children of varied ages, intellects, presenting clinical difficulties, and learning potential. Though the law requires classification, children do not wear signs announcing their afflictions and diagnoses, and their examinations do not really permit the affixing of labels as we traditionally do. The variations, even among diagnostic aspects of retardation, emotional disturbance, and neurological impairment are myriad. What follows is a report of five years' work in dealing with these issues, including background history, opinions and recommendations.

The History of Special Education in New Jersey

Before 1954, there was no formal requirement for special education of handicapped children in New Jersey. Indeed, some forward-looking school districts elected to provide special classes, primarily for their retarded children, but there was no reimbursement from the state. Senator Alfred Beadleston and the State Senate, in 1954, were responsible for the enactment of legislation which required "each local public school district to identify and classify all handicapped children between the ages of five and twenty and to provide an appropriate educational program for them . . . diagnosis and classification shall include comprehensive medical examination, psychological evaluation, social case study, and educational assessment by approved child study team personnel functioning jointly."

Between 1959 and 1970, successive revisions of the law resulted in elaborate categorizing of handicaps, with reimbursement to the local district depending on the type of handicap (Table 1).

Table 1

Maximum Annual Tuition Rates* Effective September 1, 1973

Category of Handicap	*Maximum Annual Tuition*
Emotionally Disturbed	$4,000
Neurologically Impaired	3,700
Visually Handicapped	3,350
Auditorily Handicapped	3,100
Multiple Handicapped	**
Trainable Mentally Retarded	3,400
Educable Mentally Retarded	2,850
Communication Handicapped	2,550
Socially Maladjusted	2,000
Orthopedically Handicapped	2,200
Chronically Ill	2,100

*Rate for minimum 180 day school year. Tuition rate for children enrolling during school year should be prorated.

**Maximum rate for child's major handicap may be used for tuition purposes.

New Jersey Department of Education, Division of Curriculum and Instruction, Bureau of Special Education Services

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The admittance of a particular pupil to a special education class is not haphazard. The coordinator, under the regionalized special education program, attempts to find a public school class within the district, within the "region" or, lastly, in a nearby "region," before considering private schooling.

Special Education in Region III

Region III is one of seven special education regions in Bergen County designated by the county superintendent of schools for the purpose of coordinating services to handicapped children. Region III comprises nine communities in northeastern Bergen County which have a combined population of approximately 40,000. Middle class values and conservative or moderate political views prevail. There is no high-rise zoning and minority-class children number only in the scores. There is strong emphasis on upward mobility and parents see the schools as the vehicle to success for their offspring. This report deals with pupils through the eighth grade.

Role of the Coordinator

The office of special education, housed in a modern neatly-appointed curriculum center, offers the separate districts, in the person of the coordinator, a resource individual who is trained to assist in any situation relevant to the education of the handicapped child. He assists the district child study teams primarily, and classroom teachers and principals when necessary, in the articulation of needs and services for the exceptional child. This consultation service would be much too costly, and hence impractical, to be provided in the individual districts.

The Psychiatrist's Contribution

The psychiatrist has been employed continuously by Region III since January 1969, in connection with the requirements of the New Jersey Beadleston Act. Since there was no precedent for psychiatric consultation on a formal basis, that role was originally defined by the psychiatrist-author according to (1) what seemed to be the needs of the Region and (2) his own interests and available time. Interestingly, the original and tentative plan has been maintained over the subsequent five-year period with only slight modifications.

In order smoothly to introduce this new consultation service the psychiatrist appeared at least once in each district, during the first two years, for either a lecture-seminar with the teachers and administrator or a parent-teacher evening meeting.

It was decided that the psychiatrist should be an itinerant who would see children in their own school environment (and *in* the classroom when indicated) rather than in the fairly centrally-located Region III offices. This practical method is, however, not universally used in other Regions. A three-hour (and later two-hour) block of time was set aside, weekly, during the 38-40 week school year. Originally, a strict rotation system was employed, with the psychiatrist appearing at the respective district to examine any child designated by the child study team. However, various districts could not utilize this regular service while other districts were invariably seeking more frequent consultations. Arrangements were changed so that appointments could be "booked" in advance by the various districts through the coordinator's office. Hence, there is generally a 3-6 week wait for regular consultations. Emergency consultations are offered via utilization of strategic "open" times in the psychiatrist's schedule, approximately monthly, or by juggling appointments. Any "open" consultation time not spoken for is filled with trips for special class observation in the company of the coordinator or for familiarization visits to prospective private or hospital facilities relevant for a particular child.

The child study teams of each district select the children who need psychiatric evaluation. Most often an opinion is sought as to the suitability of a child for a specific special education placement. The usual background data are made available for the perusal of the psychiatrist: a social history, health summary, anecdotal accounts from teachers, and psychologi-

cal testing results are mandatory. Frequently a learning assessment report is provided and, sometimes, outside neurological examination opinions are included. These data are summarized on a single sheet by the teams for the convenience of the psychiatrist. The psychiatric examination of the child then proceeds, sometimes including classroom observation and often including a modified neurological examination. A verbal *and written* opinion and recommendations are promptly offered the team (one of its members is invariably present) and within a week the final, typographically correct, report is mailed to the child study team. With this *immediate* sharing of findings the team can meet with the parents regarding results within days, where this is indicated. Recommendations to the team vary from suggestions regarding psychotherapy in the community, to referral for special class placement, to direct opinions about medication (Table 2). In no case is psychotherapy provided by the psychiatrist and no prescriptions are written. That is, parental permission is obtained for forwarding recommendations to suitable treatment agencies, physicians, private practitioners, and so on. Some districts, especially in medically or neurologically sticky situations and newly "discovered" psychosis problems, prefer to schedule parent conferences immediately following psychiatric examination. In such cases the psychiatrist, in the company of the child study team, meets the parents and offers an opinion, recommendations, and support.

Table 2

Treatment Recommendations—5 Years
N=162

	Cases	
	No.	*%*
Medication		
Medication alone[1]	5	3.1
Medication[1] with other plan[2]	83	51.2
No Medication		
Therapy alone[3]	12	7.4
Therapy[3] with other plan[2]	54	33.3
Other		
No recommendation—no diagnosis	6	3.7
No recommendation—no disorder	2	1.3
Total	162	100%

[1]Continued, started or changed

[2]Remedial help, various psychotherapies, residential placement, etc. in assorted combinations

[3]Individual, group, parent, family in assorted combinations

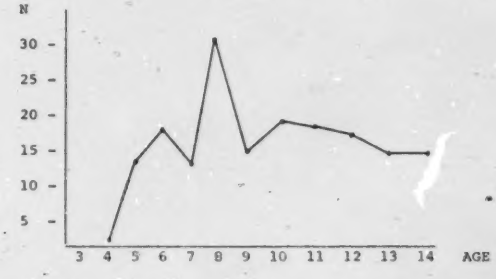
Survey of Five Years

In the five years (1969-1973 inclusive) 162 children were evaluated by the psychiatrist-author. (Twelve of these 162 children were subsequently re-evaluated with results not included here). In 150 of the 162 cases the standard psychiatric examination was employed. In five cases, the children were not seen formally and recommendations were made on the basis of a conference with the teacher, with multiple professional reports available; in seven cases, examination consisted of classroom observation, teacher conference, and reading of reports.

The age range of the children was 4 to 14, with a fairly even distribution for ages 5-14, except for age 8 which was significantly over-represented (see figure #1). The explanation for this is that age 8 coincides with the 3rd grade, at which point (1) learning disabilities become more dramatic (2) persistent behavior antics, more easily tolerated in 1st and 2nd grades, are unacceptable (3) there are, pragmatically speaking, more varied types of special education classes available for consideration by referring child study teams.

Figure 1

Age Distribution of Children Examined
N=162



The gender distribution of referrals was 136 males to 26 females or approximately 5:1, which follows the expected pattern of childhood emotional and learning problems, in which females seem less demonstrably deficient. This ratio also reflects the greater hyperkinetic-learning-organic panorama of problems (MBD Syndrome) variously reported as 4:1 to 8:1 more prominent in males (Paine).

Over half (87 of 162) of the children seen had some "organic" features (Table 3). This is testament to a somewhat changed perspective in child psychiatry, over the past ten years or so, in which behavior and learning difficulties in children are less and less frequently viewed as primarily the result of parent foul-ups, internalized conflicts, or aberrant neighborhood socio-cultural influences. Classes for children with constitutional deficiencies, in the learning-hyperkinetic-organic panorama axis, are now available, along with learning

Table 3

Psychiatric Diagnosis of Children—5 Years
N=162

	No.	%
Organicity		
OBS[1] (Organic Brain Syndrome) Mild	43	26.5
OBS Severe[2]	4	2.4
OBS and Behavior Disorder[3]	29	17.9
OBS and Retardation and Psychosis	2	1.3
OBS and Retardation	6	3.7
OBS and Psychosis	1	.6
Retardation only	2	1.3
Schizophrenia		
Childhood Schizophrenia	6	3.7
Latent Schizophrenia	1	.6
Behavior Disorders[3]		
ARC, BD, PD, Neurosis	60	37.1
Other		
Deferred[4]	6	3.7
No Psychiatric Illness	1	.6
Social Maladjustment Only	1	.6
	162	100%

[1]Hyperkinetic, Minimal Brain Dysfunction Syndromes, Learning and Speech Disability

[2]Includes Brain Trauma (2), Toxoplasmosis (1), Tuberculous Meningitis (1)

[3]Includes Adjustment Reaction Childhood, all Behavior Disorders Except Hyperkinetic, Personality Disorder, Neurosis

[4]Later Diagnosis: OBS and BD (3); Behavior Disorder (3).

disabilities specialists, for early identification of problems. Teachers are more alert and less naive, and parents are more sophisticated and well-read. This diagnostic direction is not, however, another illustration of Parkinson's Law—e.g. invent a new classification, provide classroom space, and soon have hordes of children to fill it. Rather, it is the result, finally, of success in offering children with assorted learning and behavior problems the twin devices of (1) special education (whether that be tutorial help, a resource room, or a special classroom) and (2) medication—sometimes separately, but often concurrently. It is to be noted that, for the purpose of this report, all non-psychotic and non-organic children's diagnoses have been arbitrarily lumped together—adjustment reaction of childhood (ARC), personality disorder PD, behavior disorder BD, and neurosis, not surprisingly, make up the next largest subgrouping, 60 of 162 or 37 percent.

Schizophrenia was found in 7 of 162, or approximately 4 percent of the children. When diagnosed it was thought to be *qualitatively* different from all other entities. However, much recent work supports the notion that childhood schizophrenia is a misnomer and that there are, rather, several types of childhood psychosis (with "organic" traits), instead of a childhood version of adult illness constellation known as schizophrenia (Eisenberg, Ritvo).

In just two cases was psychiatric illness not diagnosed. One child was the sibling of a diagnosed disturbed youngster and had no disorder; the other was seen to be suffering from culture shock following geographical dislocation.

As to treatment recommended, in 88 of 162 cases, medication was considered advisable (Table 2). Of course, a number of these children were already receiving medication *via* a clinic or private practitioner; a change in brand or adjustment of dosage was sometimes suggested. For the remainder, the recommendation for a trial of medication was innovative, however. In only 5 of the 88 cases was medication, *exclusively*, seen as the prospective "answer." That is, in the 83 cases in which medication was considered, additional, concurrent plans were usually recommended, including the full range of traditional treatment services—from residential placement, as the most radical, to remedial help, as the most conservative, and including resource rooms, individual, group, or family psychotherapy, speech therapy, and so on. In only 12 cases psychotherapy alone, in one of its forms, was suggested. In 54 cases psychotherapy in addition to one or several of all the *other* mo-

dalities of treatment *except* medication was favored (Table 2).

A breakdown of specific medication recommendations is beyond the scope of this paper. In perhaps 75 percent of cases, however, the analeptic preparations, Dexedrine® and Ritalin®, were favored as first choice, following a diagnosis in the minimal brain dysfunction "family." With the remainder of children, "organic" as well as "non-organic," a variety of major or minor tranquilizers or anti-depressants was recommended.

The fairly specific diagnostic results (Table 1) demonstrate that we have faithfully moved to examine and diagnose children in the traditional way over this five-year period, as the law demands. However, we have been interested in excellence rather than mere nosology. In fact, our own diagnostic results have occasionally thwarted our placement efforts (for example, finding emotional disturbance rather than organicity in a child at a time when our only opening was in a neurologically impaired program) but we have resisted the temptation to manipulate. With children who present several concurrent diagnoses, however, we can choose the special class which would be most beneficial, taking into consideration the variables of age, gender, class program, and teacher style.

Problems

Despite the lure of fifty percent reimbursement for expenses incurred in educating a handicapped child in New Jersey, many districts are reluctant to establish new classes. The cost of a new class may exceed fifteen thousand dollars the first year. Moreover, these monies are sometimes not returned to the district for (in some cases) nearly two years. The public cannot easily understand this game of numbers and the invariable increase in total expenses *plus $15,000* is considered inflationary. In addition, Boards of Education rarely delineate reimbursement figures for special education, which are reported in a total amount along with other state aid monies. Therefore, the coordinator must at times do a selling job with administrators and boards. Happily, his clientele are often sensitive, concerned educators and trustees who are knowledgeable money managers at budget time.

Perhaps the most controversial issue in the education of handicapped children is the question of how that job is best accomplished. The debate between the advocates of "mainstreaming" and the advocates of "self-contained" has existed for decades (Graham; Hilgard). At present, with the popularity of the newer Resource Room concept (Hammill) few special educators openly dare to challenge the premise that handicapped children should be kept as physically and socially close as possible to their "normal peers" (Brenton). But what about severely retarded or severely autistic children in Resource Rooms? In short, the Resource Room compromise is viewed by many well respected professionals as "pie in the sky" thinking and hardly a panacea for the problem of educating *all* exceptional children. In any event, neither children nor parents are happy with special class labels. No matter how carefully designations of classes as "special" are avoided, there is universal recognition of a status difference by children and adolescents who, inevitably, are "cruel" to their peers. The epithets of "stupid" and "retarded"—a regular occurrence—are attested to by the tears of the victims, witnessed by all professionals who have worked with such children. The pendulum has swung slowly back and forth over the last four decades as to the best method of educating exceptional children and, inevitably, will continue to swing.

No discussion of problems besetting the special educator and the consulting psychiatrist would be complete without a few thoughts regarding the absurdity of our classification system. We are certainly well meaning as we figuratively inspect the signs these children wear around their necks so that special classes can be homogeneous. But, there is rarely a pure breed of handicap. Emotionally disturbed children of the psychotic-autistic variety are, more and more, noted to have subtle and/or debilitating organic features in care-

ful clinical examination. Some of these children, moreover, function at such a level of intelligence as to be formally "retarded." Logic dictates that all "retarded" children ultimately have an "organic" or "brain injury" legacy, whether that be on a constitutional or ante-natal basis. To this extent, mental retardation is a redundant term, as all such children are ultimately "brain damaged." Children who are "socially maladjusted" quite frequently have subtle or severe learning disabilities which result in compensatory acting out. These are the children who would rather be regarded as "bad" than "dumb" (Kozol). Even with severe neurologic impairment, it is clear that comparatively few children present themselves as exclusively having cerebral palsy or some hereditary, stigmatized disorder; rather, some accompanying learning or emotional problem is frequent. As regards mild neurological impairment (the hyperkinetic syndrome), there is a vast panorama of learning and behavior problems subsumed, in assorted combinations (Clements, *et al.*). Such children, while attempting to compensate, can appear "socially maladjusted," which further clouds the issue. Often, therefore, the primary signs of dysfunction in the child are obscured by secondary or even tertiary problems. In the Diagnostic and Statistical Manual of the American Psychiatric Association—1968, we are ordered to diagnose retardation *first*, if it is manifest. These complications inevitably result in multiple diagnoses, as in our series (Table 2). Of course, it would be better to employ a multi-axial classification of child psychiatric disorders (Rutter), but that is apparently an idea whose time has *not* come. In any event, some greater flexibility with classifications is needed, so that handicapped children can be placed in the most beneficial program available *for them*, without regard for rigid diagnostic categorizations.

Summary and Comment

The authors discuss the origin of special education services in the public schools of New Jersey and its implementation in Region III of Bergen County. The roles and methods of the special education coordinator and consultant psychiatrist are discussed. A review of five years' experience in psychiatric examination and diagnosis of referred children indicates a fairly large proportion of *organically* handicapped children. It is noted that New Jersey's present elaborate scheme for defining the various handicaps is inappropriate, since most children present mixtures rather than "pure" syndromes. A "nuts and bolts" kind of description of the way the authors work is presented. Some aspects of the actual philosophy of special education are discussed and a recommendation for a more flexible method of placing children in special education classes is offered.

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